

1 Terry Goddard
2 Attorney General
2 Firm No. 14000
3 Dean E. Brekke # 016394
4 Assistant Attorney General
4 1275 W. Washington, CIV/LES
5 Phoenix, Arizona 85007
5 Tel: (602) 542-7031
6 Fax: (602) 364-3202
6 Attorneys for the State

7 **BEFORE THE ARIZONA MEDICAL BOARD**

8
9 In the Matter of:

No. MD-03-1232
MD-04-0523

10 **ROBERT L. BERRY, M.D.**

11 Holder of License No. 23069
12 For the Practice of Allopathic Medicine
13 In the State of Arizona.

**CONSENT AGREEMENT FOR
SURRENDER OF ACTIVE LICENSE**

14 Respondent.

15
16 In the interest of a prompt and judicious settlement of the above-captioned matter
17 before the Arizona Medical Board (Board) and consistent with the public interest, statutory
18 requirements and responsibilities of the Board and pursuant to A.R.S. § 41-1092.07(F)(5)
19 and A.R.S. § 32-1451(T), Robert L. Berry, M.D. (Respondent) and the Board enter into this
20 Consent Agreement and Order as the final disposition of this matter.

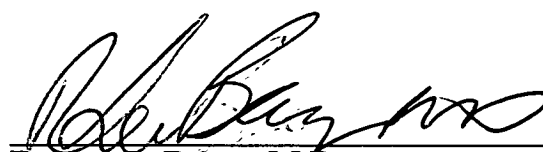
- 21 1. Respondent acknowledges that he has read and understands everything
22 contained in the Consent Agreement, Findings of Fact, Conclusions of Law,
23 and Order, and admits the Findings of Fact.
24 2. Respondent understands that by entering into this Consent Agreement and
25 Order, Respondent voluntarily relinquishes any rights to challenge in state or
26 federal court this Consent Agreement and Order in its entirety as issued by the
Board and waives any other cause of action related thereto or arising from the

Order.

3. Respondent acknowledges and understands that this Consent Agreement and Order will not become effective until approved by the Board and signed by the Board's Executive Director or designee.
4. All admissions made by Respondent in regards to these matters are solely for final disposition of these matters and any subsequently related administrative proceedings are civil litigation involving Board and Respondent. Therefore, admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal regulatory agency proceeding, civil or court proceeding, in the State of Arizona or any other state or federal court.
5. Respondent acknowledges and agrees that, upon signing this agreement and returning this document to the Board's Executive Director, Respondent may not revoke his acceptance of the Consent Agreement and Order or make any modifications to the document, regardless of whether the Consent Agreement and Order has been issued by the Executive Director. Any modifications to this original document are ineffective and void unless mutually approved by the parties.
6. Respondent further understands that this Consent Agreement and Order, once approved and signed, shall constitute a public record which may be publicly disseminated as a formal action of the Board.
7. If any part of the Consent Agreement and Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.
8. Respondent agrees that he will not reapply for license to practice allopathic medicine in the State of Arizona from five (5) years after the effective date of this agreement and order.

1 9. The parties mutually understand and agree that this order constitutes a final
2 decision in this matter under investigation by the Board and referenced above.
3

4 ACCEPTED BY:

5
6 
7 Robert L. Berry, M.D.

8 DATED: 4/20/05
9

10 _____
11 Attorney for Respondent

12 **FINDINGS OF FACT**

- 13 1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing
14 and regulating the practice of allopathic medicine in the State of Arizona.
- 15 2. Robert L. Berry, M.D. ("Respondent") is the holder of a License No. 23069 for the
16 practice of allopathic medicine in the State of Arizona.
- 17 3. The Board initiated investigation MD-03-232 in November, 2003, after receiving a
18 notice that Respondent was under investigation in the State of Washington for
19 possible unprofessional conduct. On April 26, 2004, Board staff received an action
20 report from the Washington State Department of Health, that Dr. Berry had been
21 summarily suspended from the practice of medicine on March 17, 2004.
- 22 4. The Washington Board found that Respondent practiced as a locum tenens
23 anesthesiologist at Kadlec Medical Center in Richland, Washington.
- 24 5. Patient One was a G3P5 who had delivered an 8-pound 3-ounce female infant in
25 November, 2002. Following the delivery, Respondent was scheduled to provide
26 anesthesia for this patient for a tubal ligation and umbilical hernia repair. Patient One

- 1 was brought into the operating room just before 1500 hours.
- 2 6. Prior to initiating anesthesia, the Respondent incorrectly filled out the patient's pre-
3 anesthetic assessment. He listed bee stings as an allergy to medication; he did not
4 record the patient's weight, height, vital signs, lab work and whether or not she had
5 any prior anesthetic complications. He did not note her scheduled surgery.
- 6 7. Respondent initiated anesthesia to Patient One at 1524, using Fentanyl, Versed,
7 Propatyl and Rocurium. He estimated that Fentanyl and Rocurium (paralytic agents)
8 would last approximately 30 minutes.
- 9 8. Patient One was connected to and monitored by ECG, heart rate, pulse oximetry, and
10 blood pressure machines. A Solar 800 M pulse oximetry machine was available and
11 capable of providing a printout of her blood pressure, pulse, and percent of oxygen
12 saturation.
- 13 9. During the course of the procedure, Respondent did not monitor and document the
14 patient's blood pressure, heart rate, respirations and oxygen saturation.
- 15 10. At 1530 Patient One's heart rate as indicated by the pulse oximetry machine was 42
16 and her blood pressure was 99/70. The alarms on the pulse oximetry machine had
17 been turned off. Respondent did not ensure that the alarms were turned on.
- 18 11. Respondent's anesthesia record lists the blood pressure at 1530 as 130/70. He
19 subsequently admitted that his record was created after Patient One coded and was
20 not accurate.
- 21 12. At 1534 Patient One's surgery was completed and a dressing was placed over her
22 incision. About this time, Respondent gave Patient 100 mg of Demerol in
23 anticipation of the end of surgery despite the fact that the Fentanyl was still in effect.
- 24 13. Respondent extubated the patient at about 1534. Respondent claims that he gave her
25 Neostigmine to reverse the paralytics. However, there is no record that Patient One
26 was given Neostigmine on the anesthesia record or the billing record.

- 1 14. At 1535 Patient One's heart rate was 66, and her blood pressure was 76/39.
2 Respondent did not note her hypotension or effectively relate to it. He removed the
3 patient's ECG leads and her blood pressure cuff.
- 4 15. Subsequently, Respondent noted that the waveform on the pulse oximetry machine
5 was abnormal. He asked the nurse to check her pulse oximeter monitor. The nurse
6 noted that the patient's fingers were blue, that she had no pulse, and she was not
7 breathing.
- 8 16. Rather than immediately call a code, Respondent reapplied the ECG leads. At 1540
9 the pulse oximetry recorded no heart rate, a mean blood pressure of 25 and no oxygen
10 saturation.
- 11 17. CPR was administered to Patient One at 1541. Respondent intubated the patient at
12 1543. Although she was resuscitated, she sustained severe anoxic brain injury that
13 resulting in her remaining in a vegetative state.
- 14 18. On Respondent's Washington license application, submitted by him about September
15 30, 2001, Respondent indicated "no" to all the personal data questions relating to
16 current use, including illegal use, of chemical substances that would impair the
17 applicant's ability to practice medicine. Respondent also did not disclose a previous
18 admonishment from his anesthesiology group in Louisiana for reporting to work on
19 several occasions impaired and unable to perform his duties.
- 20 19. On the day of Patient One's surgery, nursing staff noted that the Respondent looked
21 ill and appeared diaphoretic and congested. On November 14, 2002, shortly after the
22 incident described above, Respondent admitted to the hospital administration that he
23 diverted Demerol from patients and had been misusing controlled substance drugs
24 during this period.
- 25 20. A survey of Respondent's withdrawal of medications from the medical center's
26 dispensing system indicated four patients who had not received medications

1 Respondent withdrew to give to them.

2 21. Respondent subsequently surrendered his Washington license.

3 22. On February 10, 2005, the Board ordered that Robert L. Berry, M.D., the holder of
4 a License No. 23069 to practice allopathic medicine in the State of Arizona is
5 suspended pending a formal hearing before a hearing officer from the Office of
6 Administrative Hearings.

7 23. Respondent admits that these acts, described in the foregoing paragraphs 1 - 22,
8 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(o) (action taken
9 by another licensing jurisdiction) and A.R.S. § 32-1401(27)(ll) (conduct the board
10 determines is gross negligence, repeated negligence or negligence resulting in harm
11 to or the death of a patient.

12 **CONCLUSIONS OF LAW**

13 1. The Board possesses jurisdiction over the subject matter and over Respondent
14 pursuant to A.R.S. § 32-1432.02.

15 2. The Board possesses statutory authority to enter into a consent agreement with a
16 physician and accept the surrender of an active license from a physician who admits
17 to having committed an act of unprofessional conduct as contemplated by A.R.S. §
18 32-1451(T)(2).

19

20

21 **ORDER**

22 Based on the above findings of fact and conclusions of law and pursuant to the
23 authority granted to the Board by A.R.S. § 32-1451(T),

24 IT IS HEREBY ORDERED, that license number 23069, issued to Robert L. Berry,
25 M.D., for the practice of allopathic medicine in the State of Arizona, be deemed surrendered
26 and that he immediately return his wallet card and certificate of licensure to the Board.

1 DATED this 11th day of May, 2005.

2 ARIZONA MEDICAL BOARD

3 [SEAL]



4 By: Timothy C. Miller
5 Timothy C. Miller, J.D.
6 Executive Director

7 Original of the foregoing filed this
8 13th day of May, 2005, with:

9 Arizona Board of Medical Examiners
10 9545 E. Doubletree Ranch Road
11 Scottsdale, Arizona 85258

12 Executed copy of the foregoing
13 mailed by U.S. Certified Mail
14 this 13th day of May, 2005, to:

15 Robert L. Berry, M.D.
16 329 Dummyline Road
17 Madisonville, LA 70447-9693

18 COPY of the foregoing mailed
19 this 13th day of May, 2005, to:

20 Dean E. Brekke
21 Assistant Attorney General
22 Attorney General's Office
23 1275 W. Washington, CIV/LES
24 Phoenix, Arizona 85007

25 Information Services
26